



**Riverwoods Neurological Center**  
**Pamela L. Vincent M.D., PC**  
 280 West River Park Drive, Suite 350  
 Provo, UT 84604

HIPAA Disclosure Authorization Form Request  
 For Protected Health Information (PHI)

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
 \_\_\_\_\_ to disclose protected health information  
 about me as described below:

1. The following person or class of persons, or facility may receive the disclosure of protected health information:

Pamela L. Vincent, M.D., PC  
 280 West River Park Drive, Suite 350  
 Provo, UT 84604  
 FAX: (801) 229-1067  
 TEL: (801) 229-1014

2. Specific information to be disclosed is: (if blank the complete record will be disclosed)

3. I understand that if the person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.

4. I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to the Medical Records Manager. However, if I do revoke this authorization my revocation will not affect any prior actions taken in reliance on my authorization.

5. This authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_(MM/DD/YYYY); or upon the following event:

I certify that I have read, signed and received a copy of this authorization

\_\_\_\_\_  
 Signature of Patient or Patient's Representative

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Patient's Date of Birth

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship of Representative to Patient

\_\_\_\_\_  
 Representative's DOB or SS#